Supporting Older People in Care Homes at Night

Supporting Older People in Care Homes at Night

Diana Kerr, Heather Wilkinson and Colm Cunningham report on their action research study, which looked at night time care practices in care homes.

Residential and nursing homes exist to provide a twenty-four hour service. However, many research projects have focused on the day time care and provision, and there is very little literature around about night time care indicating a need to better understand night time care

Despite a policy emphasis on providing good care options that promote choice for older people (Help the Aged 2007; Alzheimer Society 2007) and that recognise the need to improve care standards in residential settings (Dept of Health 2000), standards or expectations specific to the provision of care through the night are notably absent from both legislation and policy guidance (Dept of Health 2000; Scottish Executive 2001, 2005).

Regulation bodies[1] in each country of the UK are tasked with ensuring that a standard of care is provided and informed by a set of national care standards based on principles of good care. These Standards describe the overarching principals that must inform service provision. They do not make any specific reference to the needs of older people at night.

The general lack of attention given to night time practices and experiences at macro and micro levels led to the development of the project described in this paper. The 20-month action research study[2] was carried out in Scotland where 'care home' is defined in the regulation of Care (Scotland) Act as 'a service which provides accommodation, together with nursing, personal care or personal support, for persons by reason of their vulnerability or need' (2001 p2). Care home, therefore, covers the same provision as nursing and residential care in the rest of the U.K.

The study had two main stages: first, it explored through observations and interviews the experiences, practices and perspectives of staff, residents, managers and relatives affected and/or involved in night time care. Areas of night time practice in care homes that required improvement were identified. Care Commissioners were also interviewed at this stage. Stage two involved action research (implementation and evaluation) to determine if and how night time care could be improved through a small number of interventions.

To put the findings into context it is important to note the significant difference between the day and night time environments in care homes. Night times in care homes, unlike the day time when the outside world comes in, are times of withdrawal. In the day relatives, staff, nurses, doctors and others all enter the home and residents may go out. At night the door is locked against the outside world.

[1] The Scottish Commission for the Regulation of Care; The Registration and Quality Improvement Authority Northern Ireland; The Commission for Social Care Inspection, England and Wales.

[2] Funded by The Joseph Rowntree Foundation

Some findings from stage one

Care homes are not routinely inspected at night. Inspections were generally only made when there was a complaint or cause for concern. This practice means that there is less knowledge about the time when residents are highly vulnerable(Barczi and Juergans 2006). It is also the time when staffing levels are lowest and when the least well trained staff are on duty.

The lack of involvement amongst Commissioners in night time care was also reflected in the limited home management involvement at night time. Where there was management involvement it tended to be at the very beginning of the night shift. The researchers identified a number of critical night time practices that management were unaware of, were not monitoring and consequently were unable to influence.

This lack of management involvement along with the lack of routine involvement by the regulatory body left night staff feeling undervalued and isolated from the running of the home. The sense of being unsupervised and isolated also led to staff feeling vulnerable to potential criticism, partially because of the lack of discussion with and support from management. Staff reported a 'What if' anxiety: 'what if' someone dies in the night and is not found until the morning; 'what if' someone needs their pad changed, 'what if' someone falls, 'what if' there is a fire and so on.

This anxiety coupled with a lack of supervision and a fear of criticism led to an overzealous practice of 'checking'. Routine and indiscriminate 'checking' for breathing, falls and incontinence amongst residents occurred throughout the night. This was done as often as every hour in one home but every three hours elsewhere. This checking was intrusive and disturbing to residents. It caused agitation and distress.

"One of the night nurses, sometimes she gets the door open just to see if you're all right. But I'm never usually sleeping but it does disturb me, because I know there's somebody came in my door" (Woman with dementia).

"I am fast asleep and then they open the door and put on the light and I jump awake, my heart jumps and then I cannot get back to sleep" (Woman with dementia).

Staff changed incontinence pads even when the coloured strip indicted that there was no need. In some homes the problems of the pads was exacerbated by the fact that it was day staff who ordered pads that were not suitable for night time support.

The views and experiences of residents revealed the impact of night time practices on their sense of well being. The checking, for one man, was seen as a reassurance and a source of company through the night. For others the checking was seen as unnecessary, intrusive and a cause of fright and agitation. The researchers were asked by some residents to ask the staff to stop checking them.

Night staff received lower levels of training than day staff. The Scottish Social Services Council required that by 2005, 50% of all staff in care homes should be trained to at least SVQ level 2 (this level does not discriminate between day and night staff). This study found that night staff training levels fell well below the 50 % level. Where training and modules do exist they are often directed towards day time issues

and do not specifically address night time practice. Night staff received little or no training on how to respond to people with dementia, how to support continence, how to recognise and manage pain and how to support good hydration and nutrition during the night. Night staff felt that training content was not sufficiently directed to night time care issues, for example, managing continence at night when people are in bed and need turning is not the same issue as during the day when they are mobile and upright.

The levels of noise and light during the night were not conducive to supporting good sleep patterns. Much of the noise came from staff who talked too loudly often close to bedrooms. Noise from plumbing and buzzer/alarm systems punctuated the night time. The noise from floorboards, particularly in the newer homes, regularly woke residents.

"That's one thing at the new building, the building gets so, what do they call it? You hear the noise more than you do in the old building… Whether it's, they didn't sound it or whatever it is they do I don't know [laughs]…well you hear people in the corridor, you hear them walking" (Woman with dementia).

The amount of noise would increase towards morning as staff talked more loudly as they went about their early morning routines.

Light levels were not monitored. Bright lights were turned on when people were checked; bright lights were left on in the sitting and corridor areas at bedtime therefore depriving residents of key cues about night time and sleep.

The night time physical environment was unsuitable for people with dementia. In addition to inappropriate noise and light levels, there was a lack of orientating cues leaving people wandering around corridors confused. Mirrors in bedrooms caused people to believe others were in their room.

Night staff ratios were significantly less than those in the day. Obviously there are different tasks and demands at night but night time is when residents are particularly vulnerable. People with dementia can often be up and about and in need of care, attention and nourishment. With night staff levels *'cut to the bone'* (Care Commission Officer) there was no flexibility around staffing to cover illness resulting in a frequent, and in some cases, routine, use of agency and bank staff. Whilst this met basic staff numbers it proved to be a burden for the regular night staff who had to instruct and supervise agency staff in addition to their other duties.

Findings from stage two

Interventions (as listed below) were put in place to address some of the key issues emerging from an analysis of findings from stage one. Areas of practice were identified, in consultation with staff and management, which both required and were amenable to change. The need for changes to the physical environment was discussed with managers but it was recognised that these could not be addressed within the scope of the project.

The proposed interventions were presented to each home as an action plan. The research team met with the managers and then the staff of each home to negotiate the

implementation of interventions and the evaluation of their impact. Some interventions were site specific, others applied to all sites.

1. Managers to increase or instigate their involvement and presence on the night shift.
2. The practice of 'checking' to be reviewed.
3. Noise and light levels to be reduced and monitored
4. A member of the research team to provide dementia training to all night staff.
5. Training to be given on the maintenance of continence and the management of incontinence.
6. A night key worker system to be introduced with night care plans
7. More structured and inclusive morning handover meetings.

Increased management involvement.

Increased involvement of the managers during the action research reduced staff feelings of isolation and of being under valued. It also meant that managers had a better idea about night time practices and they were able to monitor and sometimes alter ones that were not appropriate. Night time key worker systems were set up that enabled staff to become more individually responsible for residents, to carry out night time risk assessments and develop a more discriminatory approach to care, including the frequency of checking.

Practice of 'checking' reviewed.

The change in 'checking' practices had tangible positive results including a reported increase in the amount of sleep residents were getting.

> *'(Because) we don't go into everyone's bedroom now through the night…. we found that they do get a better sleep' (night staff).*

Residents who had previously woken and then been up and out of bed were now sleeping for much longer periods, some through the entire night (this may also have been a consequence of changes to noise and light levels as well as the changes to 'checking' routines). Finally, staff also reported that many residents were '*less grumpy'* in the mornings making morning tasks easier for everyone.

Noise and light levels reduced.

There were reductions in noise levels as a result of the issue being discussed with the staff. Noise was reduced simply by increasing staff awareness and their ability to self-monitor.

'Oh yes, we have been trying our best (to be quieter). Because before we never really thought about it' (night staff).

Buzzers and resident alarm call systems were identified as a significant and enduring source of night time disturbance.

'Well (the manager) noticed the noise of the alarms through the night and he got the special night switch fitted in to silence the alarms a bit more' (night staff).

This quote illustrates well the consequence of managers being orientated towards day time activities and routines and not being aware of the different needs of night time care. In this particular home, there were pagers that staff could have used but the batteries had run down

and the use of the pagers had lapsed with the introduction of a 'new system' of buzzers. The change from pagers to buzzers had been a management decision based on day time needs.

The implementation of many other noise reduction strategies led to a noticeable change in the noise levels and fewer people being up during the night:

'I found that by keeping noise levels down that certain residents stayed in their room and seemed to get a better sleep' (night staff diary).

The importance of light, as a source of information about the time of day and night, as an indicator of the tasks that need to be achieved and as a source of agitation and sleep disturbance was highlighted. Staff recognised the need to turn the main lights down so that there was a message given about the time of night. This low level light gave a more subdued lighting level more indicative of night time and not of the morning light when people might think it was time to get up. The dim lights also provided a calming environment more conducive to sleep:

'…. like mostly we never used to switch off the lights to leave the dim lights during the night but of late we make sure that we put most of the lights off and then leave the dim lights for them during the night' (night staff).

Attention was also given to the light levels when checking or entering a resident's room and the use of torches was introduced.

'Instead of turning bright lights on, we now use torches - less startling for residents' (night staff diary).

Dementia training provided to all night staff

Training was a key element of the action research stage. Staff were given training on dementia. This was a one-day course only and in one home it was provided on two evenings at the change over time for 1-½ hours. The training was person centred, where necessary night time specific and practice based. Despite the small amount of time given there were well-evidenced, improvements in staff practice with people with dementia. Examples of change include:

- An increased awareness of how the environment can be stressful and an appreciation of the staff role in this:

  ' it was really quite good explaining even about the music, how it can actually agitate people…and the light, even just the light (night staff).

- The recognition that it is important not to collude with distressing memories that will cause the person with dementia to become stuck in their fear and distress but to use distraction when appropriate:

  'We have changed what we say when people ask for their mothers. We don't now try to get them round to realise their mother is dead. We learned to talk to them about their mother and then try to get them onto something else' (night staff).

- The realisation that people with dementia can still communicate and what might sound like rambling will have meaning if only the person without dementia listens.

> *'See since this, listening to them, it's made a big difference. It was because I was actually listening to what he was saying, it could have sounded like he was talking rubbish. Well, before (the course) we would have thought that' (night staff).*

- The recognition that staff themselves, by the use of incorrect responses and reactions, could be inducing problematic and avoidable behaviour:

> *'Since the training on dementia there has been a definite reduction in instances of challenging behaviour' (manager).*

- The recognition of the way in which diagnostic overshadowing, such as attribution of behaviours to the dementia rather than to pain, can result in people with dementia not being given adequate pain relief, particularly at night:

> *'I am much more clear about dementia and what experience the person with dementia has. I did not realise that sometimes her (resident) behaviour was because she was in pain' (night nurse).*

Maintaining continence and managing incontinence.

Only one home was able to provide any training on continence management to the night staff during the duration of this study. A specialist nurse provided the training and it was provided at 21.30 to allow night staff to attend. Whilst staff found this helpful in many ways they also had some important reservations. The training had been the same as that provided for day staff and some of this was inappropriate because of the different incontinence needs of residents at night. The difficulty of managing people who are not standing and the need to turn residents in bed and to have limited help for what was seen as heavier work were highlighted:

'That was fine (the training), but it's (night time) different altogether. Well, people are simply tired. You're rolling them in their bed. You know, people aren't standing up, waiting for us to put their pads on. They can get quite annoyed at night' (night staff).

The need for continence to be a twenty-four hour programme and not just a daytime issue was highlighted. This practice was changed by improving communication over the issue between day and night staff and resulted in an improvement in the pads provided.

A night key worker system with night care plans.

One home introduced, with management support, a night time key worker system with linked, more detailed, night time care plans. There were clear signs that this new system led to benefits for residents.

'The night care plans have nudged us all to think again about individual residents and having them (care plans) together in a 'night folder' will make them more instantly accessible and be particularly useful to new staff' (Night nurse diary).

The following comment is critical:

'The challenge will be to make sure that they (the care plans) are used and reviewed regularly' (Night nurse diary).

This would be one of the tasks that the manager, in the role of night time supervisor and manager, would pay attention to.

Handover meetings between day and night staff

In two of the homes, new handover arrangements which included more night staff were instigated to improve communication and relationships between day and night staff. This change in the content and format of the handover meeting was generally seen as an improvement:

'Change to handover was excellent. I enjoy it. Talking to other staff and the communication is excellent. Also good to meet officers (managers) at handover, good to feel part of a team and not isolated, as this can be sometimes what nightshift feels' (Night care staff diary).

There were, however, some teething problems with the changes, especially as the number of night staff members attending the handover had a potentially negative affect on the residents

'*Because you are in a hurry to get down for the report, you hurry them (the residents) we don't seem to have time because we think 'oh we need to get down there and write all this up' (night care staff).*

Despite advantages to the more inclusive handover meetings, consideration has to be given to staff cover and the impact on residents, particularly as this is a busy time when residents need much attention. Staff suggested that this problem might be alleviated by employing extra staff on a short shift between 6 and 9 in the morning.

Conclusion

This article represents only some of the findings from the study. It does however, serve to illustrate the need for more rigorous inspection by the regulatory bodies and tighter management control and involvement in night time care. It also highlights the need for targeted, accessible training, especially on dementia and the management of continence. The development of appropriate light and noise levels and the use of a night time key worker system that allows for individual night risk assessments and discriminate checking were shown to improve sleep and reduce agitation.

Recommendations

The following are a list of recommendations made in relation to those findings highlighted in this article. They are not the full recommendations.

Recommendations for Regulatory Bodies

- Include night time inspections as standard, not just as result of complaints. Inspectors should be paid accordingly.
- Inspectors must have specific awareness and training on dementia and night time issues.
- Inspectors must provide home specific and informed guidance on staffing levels for night time care. This is to take account of changes in staffing needs throughout the night
- Training modules for everyone must reflect night specific issues.
- Minimum qualification requirements must be equally applicable to night and day staff setting are addressed and where appropriate relevant

Recommendations for Home Management

- Implement regular communication and support strategies between manager and night time care staff.
- Ensure that environmental concerns within the care home setting are addressed and where appropriate relevant technology is used e.g. guidance around noise, light, safety, silent call system.
- Ensure that systems are in place for night staff to be provided with all the equipment, technology and facilities required to provide good night time care
- Monitor staff training requirements, and pay attention to appropriate times/conditions for such training to be provided.

- Keep the use of agency and bank staff to a minimum – where possible staff with a familiarity of the care setting should be used.

Recommendations for Management in connection with Night Staff

- Implement a system of regular communication with and supervision of night staff and give clear messages about the expected night time practices through specific guidance.

- Ensure a system of training is available to night time staff and encourage training by ensuring it is night time specific and at times that are appropriate and that do not impact negatively on the night staff. Training content must include dementia awareness.

- Develop and provide guidance to night staff on the impact of night working and strategies to support better health – to include information on nutrition etc.

Recommendations for Care Home with Residents

- Each resident to have a night time key worker who will take responsibility for the production and review of the night time care plans, for the communication to other staff of the residents needs and any changes and for providing a communication link between the resident and their relatives.

- Night time care plans will be used to regularly assess and communicate the needs of the resident through the night information should include regular professional assessments of needs such as continence support and pain needs.

- Practices that are intrusive such as checking and changing pads should be done with minimal disruption, be gender appropriate and be sensitive to communication needs. They should be in response to individual needs not part of a group 'round'.

The full report and recommendations are available free from The Joseph Rowntree Foundation on their web site www.jrf.org.uk Request for a hard copy of the ***findings*** can be obtained from The Joseph Rowntree Foundation 40 Water end York YO30 6WP

References

Alzheimer's Society 2007 *Home from Home*. A report highlighting opportunities for improving standards of dementia care in care homes. Alzheimer's Society, London

Barczi SR and Juergens TM 2006 Comorbidities:psychiatric, medical,medications and substances Sleep med Clin 1 PP231-245 publ Elsevier Saunders

Help the Aged 2007; *My Home Life: Quality of Life in Care Homes, A review of the literature*. Help the Aged, London

Department of Health 2000. *Care Homes for Older people: National Minimum Standards.* Department of Health, London

Scottish Executive 2001. Regulation of Care (Scotland) Act 2001. Scottish Executive. Edinburgh. Website: http://www.opsi.gov.uk/legislation/scotland/acts2001/20010008.htm Accessed 01/09/07

Scottish Executive 2005. *National Care Standards: Care Homes for Older People*, Scottish Executive, Edinburgh.